Consent to Disclose
PERSONAL HEALTH INFORMATION

I authorize _____ to ☐ disclose and/or ☐ exchange
Print Name of Health Information Custodian

the personal health information of _____
Service User Name and Date of Birth

to York Support Services Network, as the administrator of Developmental Services Ontario Central East Region

For the following purposes: ☐ confirmation of eligibility
☐ specify other *Initiate Urgent Response process*

The following restrictions apply to the collection/disclosure and/or exchange of Personal Health Information:

☐ None Apply

☐ Yes ☐ No I understand the permitted uses of personal health information as regulated by the privacy legislation

☐ Yes ☐ No All of my questions have been answered and I understand the purpose of this consent directive

☐ Yes ☐ No I have made my own consent directive decision(s) and I am signing this form voluntarily

☐ Yes ☐ No I understand that the consent directive decision(s) I have made can be changed at any time, by providing written notice to the DSO/YSSN

☐ Yes ☐ No I understand this consent directive form will be considered valid, unless the DSO/YSSN is otherwise notified, or my service with the DSO/YSSN ends

☐ *This form is signed by the service user named above*

_____ _____
Signature of Service User Signature of Witness

☐ *This form is signed by an authorized representative on behalf of the service user named above*

Consent Directive

Print Name of person signing

Relationship to Service User

Signature

Signature of Witness

Dated this_____ day of_____ 20_____,

Office Use Only: ☐ *process recorded* ☐ *consent directive registered* *Date*: